Print

DEPARTMENT OF HOMELAND SECURITY
U.S. Coast Guard

Merchant Mariner Medical Certificate Evaluation Report

OMB-1625-0040
Expires 6/30/12

Section I: Applicant Information - To be completed by the Applicant and reviewed by the Medical Practitioner

Last Name | First Name | Middle Name | Suffix *(Jr., Sr., III)* | Date of Birth *(mm/dd/yyyy)*

Age | Social Security No. (XXX-XX-XXXX) | Reference No. *(If applicable)* | Sex: ☐ Male ☐ Female

Occupation: ☐ Deck ☐ Engineer ☐ Food Handler ☐ STCW ☐ Other

Specify: _____

Application Type:
☐ Medical Certificate Only
☐ Medical Certificate to accompany one of the following: ☐ Original ☐ Renewal ☐ Raise In Grade to _____

Section II: Applicant Certification and Release - To be completed by the Applicant and reviewed by the Medical Practitioner

My signature below attests, subject to prosecution under 18 USC 1001, that all information provided by me on this application form is complete and true to the best of my knowledge, and I agree that it is to be considered part of the basis for issuance of any medical certificate to me. I have not knowingly omitted any material information relevant to this form. I have also read and understand the Privacy Act Statement that accompanies this form.

I hereby authorize the medical practitioner, who has signed the certification on page 6 of this form, to release to, or discuss with authorized Coast Guard personnel, any pertinent information in his/her possession regarding any physical or medical condition that may require review by the Coast Guard prior to determining whether the Coast Guard should issue a medical certificate for maritime service.

I understand that this authorization is voluntary. I also understand that failure to provide authorization could affect the Coast Guard's ability to make a timely determination as to whether the Coast Guard should issue me a medical certificate for maritime service. This authorization will remain in effect until the Coast Guard determines whether to issue me the requested medical certificate for maritime service, but no longer than one year.

I have read and understand the following statement about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the medical practitioner in writing but the revocation will not have any effect on any actions taken before they received the notification.
- Upon request, I may see or copy the information described in this release.
- I am not required to sign this release to receive my medical evaluation.

Name *(First Name)* *(M.I.)* *(Last Name)* | Signature | Date *(mm/dd/yyyy)*

Third Party Release:

By checking the following boxes, I am authorizing release of information to the third party as indicated below. If a selection is made, please provide the name of organization or third party, address, and phone number. Additional third party release information can be attached separately.

☐ Act on my behalf in all matters pertaining to the processing of my current USCG medical certificate application

Name (First Name) (M.I.) (Last Name)

Name of Organization or Third Party: _____

Organization Point of Contact (if applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

( ) --

Phone Number (000) 000-0000

Section III: Medications - To be completed by the Applicant and reviewed by the Medical Practitioner

The information reported by the applicant must be verified by the medical practitioner to include the following two items.

1. Report all medications (prescription and non-prescription), dietary supplements, minerals, performance enhancing substances, and vitamins prescribed, filled, and/or taken within the last 30 days or used for 30 or more days within the last 90 days.
2. Include dosage and frequency taken of every substance on this form, as well as the condition for which each substance is taken.

Additional sheets may be added by the applicant and/or medical practitioner if needed to complete this section. (Include applicant name and date of birth on each additional sheet.)

If none, check "NONE". ☐ NONE

_____

_____

_____

_____

Section IV: Medical Conditions

Have you ever had, been treated for, or do you presently have any of the following conditions?

- ☐ Yes ☐ No 1. Eye/vision problems except glasses
- ☐ Yes ☐ No 2. Ear/nose/throat problems or other ENT problems/surgery
- ☐ Yes ☐ No 3. High or low blood pressure
- ☐ Yes ☐ No 4. Heart or vascular disease of any kind
- ☐ Yes ☐ No 5. Heart surgery and/or implanted devices (pacemaker, defibrillator, etc.)
- ☐ Yes ☐ No 6. Lung disease of any type (asthma, bronchitis,emphysema, etc.)
- ☐ Yes ☐ No 7. Any blood disorder (anemia, hemophilia, blood clots, polycythemia, etc.)
- ☐ Yes ☐ No 8. Diabetes, glucose intolerance, or sugar in urine
- ☐ Yes ☐ No 9. Thyroid problem
- ☐ Yes ☐ No 10. Stomach, liver, or intestinal disorder
- ☐ Yes ☐ No 11. Kidney problems/stones or blood in urine
- ☐ Yes ☐ No 12. Any other urinary or bladder problems not listed above
- ☐ Yes ☐ No 13. Skin disorder or problem
- ☐ Yes ☐ No 14. Allergies or allergic reactions to any substance, medication, or food.
- ☐ Yes ☐ No 15. Infectious/contagious disease
- ☐ Yes ☐ No 16. Any sleep problems: Obstructive Sleep Apnea, Restless Leg Syndrome, Narocolepsy, Shift Work Sleep Disorder, Insomnia, etc.
- ☐ Yes ☐ No 17. Epilepsy, fits, or seizures
- ☐ Yes ☐ No 18. Loss of consciousness or memory
- ☐ Yes ☐ No 19. Frequent or severe headaches
- ☐ Yes ☐ No 20. Dizziness/fainting spells/balance problems
- ☐ Yes ☐ No 21. Frequent motion sickness requiring medication
- ☐ Yes ☐ No 22. Stroke or Transient Ischemic Attack (TIA), brain tumor or other brain disorder
- ☐ Yes ☐ No 23. Any neurologic disorder or nerve problems including numbness and/or paralysis, not listed above
- ☐ Yes ☐ No 24. Attention Deficit Disorder with or without Hyperactivity
- ☐ Yes ☐ No 25. Anxiety, depression, bipolar disorder, adjustment disorder, PTSD, or schizophrenia
- ☐ Yes ☐ No 26. Suicide attempt or Ideation
- ☐ Yes ☐ No 27. Taken medications, drugs, over-the-counter medications, supplements, or any substance to improve attention, behavior, or physical performance
- ☐ Yes ☐ No 28. Evaluation, treatment, or hospitalization for alcohol or substance use, abuse, addiction, or dependence (including illegal drugs, prescription medications, or other substances)
- ☐ Yes ☐ No 29. Any other psychiatric disorder, mental health evaluation/ hospitalization, or psychological counseling not listed above.
- ☐ Yes ☐ No 30. Back pain, joint problems, or orthopedic surgery
- ☐ Yes ☐ No 31. Amputation, prosthesis, or use of ambulatory devices (cane, walker, braces, etc.)
- ☐ Yes ☐ No 32. Fractures, recurrent dislocations or limitation of motion of any joint
- ☐ Yes ☐ No 33. Medical rejection or discharge by military or life/health insurance
- ☐ Yes ☐ No 34. Any hospital admissions not listed above
- ☐ Yes ☐ No 35. Any diseases, surgeries, cancers, illnesses, or disabilities not listed on this form.
- ☐ Yes ☐ No 36. Have you ever been signed off as sick or repatriated from a ship?
- ☐ Yes ☐ No 37. Have you ever been denied a merchant mariner credential for medical reasons?

Comments: *For each "YES" answer, please provide the following: medical condition number, diagnosis/ICD code, details, dates, treatment given, and current medical/functional status. Additional sheets may be added as needed being sure applicant name and date of birth appear on each additional sheet.*

Number	Additional Information

Applicant Name:
(First Name, MI, Last Name) _____

Date of Birth:
(mm/dd/yyyy) _____

REPORT OF MEDICAL EXAMINATION

The following sections must be completed by the Medical Practitioner

Section V: Vision

The medical practitioner must indicate test used and results (number of errors). Additional information must be reported in Section VII. Color sensing lenses (e.g. X-Chrome) are prohibited.

a. Visual Acuity

Distant Uncorrected	Distant Corrected To
Right: 20 / ____	Right: 20 / ____
Left: 20 / ____	Left: 20 / ____

Field of Vision

This applicant must have a 100-degree horizontal field of vision.

☐ Normal

☐ Abnormal

b. Color Vision *The following color sense testing methodologies are acceptable:*

☐ AOC (1965) - (6 or fewer errors on plates 1-15)

☐ AOC-HRR (2nd Edition) - (No errors in test plates 7-11)

☐ HRR PIP (4th Edition) - (No errors in test plates 5-10)

☐ Richmond (1983) - (6 or fewer errors)

☐ Titmus Vision Tester/OPTEC 2000 - (No errors on 6 plates)

☐ Optec 900 (colored lights) Test per instruction booklet.

Color Vision Testing Results:

☐ Passed ☐ Failed Number of Errors: ____

Mariner is able to distinguish red, green, blue, and yellow:

☐ Yes ☐ No

☐ Ishihara pseudoisochromatic plates test, 14 plate (5 or less errors)

☐ Ishihara pseudoisochromatic plates test, 24 plate (6 or less errors)

☐ Ishihara pseudoisochromatic plates test, 38 plate (8 or less errors)

☐ Farnsworth D-15 Hue Test (attach test results) (Engineer/radio/tankerman/MODU only)

☐ Farnsworth Lantern (colored lights) Test per instruction booklet

☐ Dvorine pseudoisochromatic 15 plate test (6 or less errors)

☐ An alternative test approved by the Coast Guard (Indicate test)

____

Section VI: Hearing

(a) An applicant with normal hearing by forced whispered voice ≥ 5 feet with or without hearing aids does not need to complete either the audiometer test or the functional speech discrimination test.

(b) If hearing is abnormal, then perform either a functional speech discrimination test at 65 dB or an audiogram documenting thresholds and averages as indicated below. Both aided and unaided values should be recorded for applicants requiring hearing aids.

(c) All applicants with an unaided threshold > 30dB in the better ear should have functional speech discrimination testing performed at 65dB.

(d) Refer to Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials from the NMC website (http://www.uscg.mil/nmc/medical.asp) for further guidance. Report any additional information or comments in Section VII.

☐ Normal Hearing ☐ Abnormal Hearing ☐ Hearing Aid Required

Audiometer Threshold Value

	500Hz	1,000Hz	2,000Hz	3,000Hz	Average
Right Ear (Unaided)					
Left Ear (Unaided)					
Right Ear (Aided)					
Left Ear (Aided)					

Functional Speech Discrimination Test @ 65dB

Right Ear (Unaided): ____ %

Left Ear (Unaided): ____ %

Right Ear (Aided): ____ %

Left Ear (Aided): ____ %

Applicant Name: *(First Name, MI, Last Name)* _____

Date of Birth: *(mm/dd/yyyy)* _____

Section VII: Physical Examination

This section should be completed by the medical practitioner or other medical staff to the satisfaction of the medical practitioner. Please make comments in the space provided on any item indicated as an "abnormal" system/organ.

Height *(inches only)*: ☐ Weight *(lbs)*: ☐ Body Mass Index*(BMI)*: ☐

Pulse Resting: ☐ Initial Blood Pressure: ☐ Repeat Blood Pressure *(if needed)*: ☐

1. Head, Face, Neck, Scalp ☐ Normal ☐ Abnormal
2. Eyes / Pupils / EOM ☐ Normal ☐ Abnormal
3. Mouth and Throat ☐ Normal ☐ Abnormal
4. Ears / Drums ☐ Normal ☐ Abnormal
5. Lungs and Chest ☐ Normal ☐ Abnormal
6. Heart ☐ Normal ☐ Abnormal
7. Abdomen ☐ Normal ☐ Abnormal
8. Upper / Lower Extremities ☐ Normal ☐ Abnormal
9. Spine / Musculoskeletal ☐ Normal ☐ Abnormal
10. Skin ☐ Normal ☐ Abnormal
11. Lymphatic ☐ Normal ☐ Abnormal
12. Neurologic ☐ Normal ☐ Abnormal
13. Vascular System ☐ Normal ☐ Abnormal
14. Genitourinary System ☐ Normal ☐ Abnormal
15. Hernia ☐ Normal ☐ Abnormal
16. Missing Extremities / Digit ☐ Normal ☐ Abnormal
17. General / Systemic ☐ Normal ☐ Abnormal

Additional Medical Comments

Item	Additional Information

Applicant Name: (First Name, MI, Last Name) ____________________ Date of Birth: *(mm/dd/yyyy)* ____________

Section VIII: Demonstration of Physical Ability

1. If the medical practitioner doubts the applicant's ability to meet the guidelines contained within this table, and for all applicants with a Body Mass index (BMI) of 40.0 or higher, the practitioner shall require that the applicant demonstrate the ability to meet the guidelines. This does not mean, for example, that the applicant must actually don an exposure suit, pull an uncharged 1.5 inch diameter 50' fire hose with nozzle to full extension, or lift a charged 1.5 inch diameter fire hose to firefighting position. Rather, the medical practitioner may utilize alternative measures to satisfy himself or herself that the applicant possesses the ability to meet the guidelines in the third column. A description of the methods utilized by the medical practitioner should be reported in the **Comments** section provided below.
2. All practical demonstrations, if required, should be performed by the applicant without assistance. Any prosthesis normally worn by the applicant, and any other aid devices, may be used by the applicant in all practical demonstrations except when the use of such items would prevent the proper wearing of mandated personal protection equipment (PPE).
3. If the medical practitioner is unable to conduct the practical demonstration, the applicant should be referred to a competent evaluator of physical ability. The Coast Guard recognizes that all medical practitioners may not have the equipment necessary to test all of the tasks as listed. Equivalent alternate testing methodologies may be used. For further information, check the Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials (http://www.uscg.mil/nmc/medical.asp).
4. If the applicant is unable to perform any of the following functions, the medical practitioner should provide information on the degree or the severity of the applicant's inability to meet the standards. The results of any practical demonstration or attendant physical evaluation should be recorded in the **Comments** section provided below.

LISTS OF TASKS CONSIDERED NECESSARY FOR PERFORMING ORDINARY AND EMERGENCY RESPONSE SHIPBOARD FUNCTIONS

Shipboard Tasks, Function, Event, or Condition	*Related Physical Ability*	*Acceptable Demonstration*
Routine movement on slippery, uneven, and unstable surfaces	Maintain balance (equilibrium)	Has no disturbance in sense of balance
Routine access between levels	Climb up and down vertical ladders and stairways	Is able, without assistance, to climb up and down vertical ladders and stairways
Routine movement between spaces and compartments	Step over high doorsills and coamings, and move through restricted accesses	Is able, without assistance, to step over a doorsill or coaming of 24 inches (61 centimeters) in height. Able to move through a restricted opening of 24 inches
Open and close watertight doors, hand cranking systems, open/close valve	Manipulate mechanical devices using manual and digital dexterity, and strength	Is able, without assistance, to open and close watertight doors that may weigh up to 55 pounds (25 kilograms); should be able to move hands/arms to open and close valve wheels in vertical and horizontal directions; rotate wrists to turn handles; able to reach above shoulder height
Handle ship's stores	Lift, pull, push, carry a load	Is able, without assistance, to lift at least a 40 pound (18.1 kilogram) load off the ground, and to carry, push, or pull the same load
General vessel maintenance	Crouch (lowering height by bending knees); kneel (placing knees on ground); stoop (lowering height by bending at the waist); use hand tools such as spanners, valve wrenches, hammers, screwdrivers, pliers	Is able, without assistance, to grasp, lift, and manipulate various common shipboard tools
Emergency response procedures including escape from smoke-filled spaces	Crawl (ability to move body using hands and knees); feel (ability to handle or touch to examine or determine differences in texture and temperature)	Is able, without assistance, to crouch, kneel, and crawl, and to distinguish differences in texture and temperature by feel
Stand a routine watch	Stand a routine watch	Is able, without assistance, to intermittently stand on feet for up to four hours with minimal rest periods
React to visual alarms and instructions, emergency response procedures	Distinguish an object or shape at a certain distance	Fulfills the eyesight standards for the merchant mariner credential applied for (see the NMC website for more info; http://www.uscg.mil/nmc/medical.asp)
React to audible alarms and instructions, emergency response procedures	Hear a specified decibel (dB) sound at a specified frequency	Fulfills the hearing standards for the merchant mariner credential applied for
Make verbal reports or call attention to suspicious or emergency conditions	Describe immediate surroundings and activities, and pronounce words clearly	Is capable of normal conversation
Participate in firefighting activities	Be able to carry and handle fire hoses and fire extinguishers	Is able, without assistance, to pull an uncharged 1.5 inch diameter, 50' fire hose with nozzle to full extension, and to life a charged 1.5 inch diameter fire hose to firefighting position
Abandon ship	Use survival equipment	Has the agility, strength, and range of motion to put on a personal floatation device and exposure suit without assistance from another individual

Demonstration of Physical Ability Results

☐ Applicant has physical strength, agility, and flexibility to perform all of the items listed above

☐ Applicant does **NOT** have physical strength, agility, and flexibility to perform any one of the items listed above

COMMENTS:

Applicant Name:
(First Name, MI, Last Name) _____

Date of Birth:
(mm/dd/yyyy) _____

Section IX: Food Handler Certification

If applicable, to be completed by the Medical Practitioner if Food Handler Certificate is sought by the applicant.

Applicant is free from communicable disease. ☐ Yes ☐ No

Section X: Summary

Applicant proof of identity verified: ☐ Yes ☐ No

Overall fitness recommendation: ☐ Competent ☐ Not Competent ☐ Needs Further Review

Supporting medical testing and documentation for medical conditions included with submission: ☐ Yes ☐ No

Comments: _____

Medical Practitioner:

This signature attests, subject to criminal prosecution under 18 USC § 1001, that all information reported by the medical practitioner is true and correct to the best of his/her knowledge and that the medical practitioner has not knowingly omitted or falsified any material information relevant to this form.

(First Name) *(M. I.)* *(Last Name)*	Signature
License Number Designated Medical Examiner (DME) number (if applicable)	Date *(mm/dd/yyyy)*
Office Address City State Zip Code	( ) - Phone Number *(000) 000-0000*

Applicant Name:
(First Name, MI, Last Name) _____

Date of Birth:
(mm/dd/yyyy) _____

Merchant Mariner Medical Certificate Evaluation Report Instructions

· Detailed guidance on the medical and physical evaluation guidelines for merchant mariner credentials can be viewed at the National Maritime Center website (http://www.uscg.mil/nmc/medical.asp).
· Additional information can also be obtained from NMC at: Commanding Officer, National Maritime Center,100 Forbes Drive, Martinsburg, WV 25404 or 1-888-IASKNMC (1-888-427-5662)

Who must submit this form?

Applicants seeking an original, renewal, or raise-in-grade credential are required to complete this form and submit it to the U.S. Coast Guard. Applicants seeking a raise-in-grade are required to submit this form if a previous medical evaluation has not been submitted within the last 3 years. Guidance for required submission of this form can be found at the National Maritime Center website (http://www.uscg.mil/nmc/medical.asp).

Instructions for Applicants

Applicants are required to complete the Applicant Information in Section I, Medications in Section III, and Medical Conditions in Section IV.

Applicants are required to sign and date the certification in Section I of this form attesting, subject to criminal prosecution under 18 USC § 1001, that all information reported is true and correct to the best of their knowledge and that they have not knowingly omitted or falsified any material information relevant to this form.

Applicants should also complete the release in Section II of this form.

General Instructions for Medical Practitioner

1. The Coast Guard requires a physical examination and certification to be completed to ensure that mariners:
   - Are of sound health
   - Have no physical limitations that would hinder or prevent performance of duties (see below)
   - Are free from any medical conditions that pose a risk of sudden incapacitation, which would affect operating, or working on vessels

2. The medical practitioner must ensure a complete history and physical are conducted and make recommendations as to the fitness of the applicant. Final approval of the mariner's status rests with the U.S. Coast Guard.

3. All examinations, tests, and demonstrations must be performed, witnessed, or reviewed by a physician (Medical Doctor [MD], or Doctor of Osteopathy [DO]), or nurse practitioner, or a certified physician assistant licensed by a state in the U.S., a U.S. possession, or a U.S. territory. The medical practitioner who performed the examination must verify Sections III and IV, and complete Sections V, VI, VII, VIII, IX, and X of this form.

4. Verification of medications in Section III of this form includes questioning the applicant about any medications or other substances reported, reviewing relevant medical conditions to determine if the applicant has omitted any medications or other substances, and affirmatively reporting any omitted current medications or other substances where required.

5. Applicants must report their relevant medical conditions to the best of their knowledge, and the medical practitioner must verify the medical conditions. Check "YES" if the applicant has had a previous diagnosis or treatment of the condition by a health care provider, or if the applicant is currently under treatment or observation for the condition, or if the condition is present regardless of treatment.
   If the medical practitioner, or any other health care provider to the satisfaction of the medical practitioner, discovers a condition not reported by the applicant, he/she must check "YES" in the appropriate block and explain in the remarks.
   The medical practitioner must address all reported conditions in this section. This detailed explanation should include, at a minimum, identification of the condition, approximate date of diagnosis, any limitations, whether the condition is controlled, the prognosis, the treatment, and any additional information as appropriate, referring to the evaluation data listed at the National Maritime Center website (http://www.uscg.mil/nmc/medical.asp).
   Additional sheets may be added by the applicant and/or the medical practitioner if needed to complete this section of the form. (Include applicant's name and DOB on each additional sheet.)
   Supporting medical documentation and testing for all identified conditions potentially requiring further review should be submitted with each application as per the guidelines found on the NMC website (http://www.uscg.mil/nmc/medical.asp).
   Detailed guidelines on medical conditions subject to further review can be found on the NMC website. Medical practitioners should be familiar with the guidelines contained within this document. Medical and Physical Evaluation Guidelines for Merchant Mariner Credentials can be downloaded from the NMC website (http://www.uscg.mil/nmc/medical.asp) or by calling the NMC at 1-888-IASKNMC (1-888-427-5662).

6. Mariners, including first class pilots and those individuals "serving as" pilots (as well as Great Lakes pilots) who are required to submit annual physical examinations to the Coast Guard, may be issued a letter by the NMC specifying the extent of the evaluation data, if any, that should be submitted to the Coast Guard for any medical conditions that have been previously reported to, and evaluated by, the NMC.

7. The medical practitioner is not required to perform or witness every examination, test, or demonstration. These may be referred to other qualified practitioners such as audiologists or optometrists; however, they must be reviewed to the satisfaction of the medical practitioner. Page 6 of this form contains a certification that the general medical examination, vision and hearing tests, as well as the physical demonstration of competence as appropriate, have been performed to the satisfaction of the medical practitioner. The medical practitioner must sign and date the certification where indicated. This signature attests, subject to criminal prosecution under 18 USC § 1001, that all information reported by the medical practitioner is true and correct to the best of his/her knowledge and that the medical practitioner has not knowingly omitted or falsified any material information relevant to this form.

8. If the medical practitioner is unable to determine the applicant's physical ability, the applicant should be referred to another health care provider who can properly evaluate and test physical abilities.

Applicant Name:
(First Name, MI, Last Name) _____

Date of Birth:
(mm/dd/yyyy) _____

9. The medical practitioner shall complete Section IX for all applicants requiring Food Handler Certification. The medical practitioner need not perform any additional laboratory testing unless it is deemed clinically necessary. Applicants and currently employed food workers should report information about their health as it relates to diseases that are transmissable through food. The following issues should be considered by the medical practitioner when certifying an applicant:

   a. The applicant reports they have been diagnosed with an illness due to organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc.
   b. The applicant reports they have at least one symptom caused by illness, infection, or other source that is associated with an acute gastrointestinal illness such as diarrhea, fever, vomiting, jaundice, or sore throat with fever.
   c. The applicant reports they have a lesion containing pus, such as a boil or infected wound, which is open or draining and is on hands or wrists or on exposed portions of the arms.
   d. The applicant reports they have had Salmonella Typhi within the past three months, Shigella spp. within the past month, Shiga toxin producing Escherichia coli within the past month, or Hepatitis A virus ever.
   e. The applicant reports they are suspected of causing or being exposed to a confirmed disease outbreak caused by organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc. This would include outbreaks associated with events such as a family meal, church supper, or festival because the food employee ate food implicated in the outbreak, or ate food at the event prepared by a person who is infected or who is suspected of being a shedder of the infectious agent.
   f. The applicant reports they live in the same household as, and have knowledge about, a person who is diagnosed with organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc.
   g. The applicant reports they live in the same household as, and have knowledge about, a person who attends or works in a setting where there is a confirmed disease outbreak caused by organisms such as Salmonella Typhi, Shigella spp., Shiga-toxin-producing Escherichia coli, Hepatitis A virus, etc.

10. Instructions for providing proof of identity
    a. Applicants shall present acceptable proof of identity to the medical practitioner conducting examinations.
    b. Medical practitioners must verify the identity of applicants before conducting examinations.
    c. Proof of identity shall consist of one current form of valid government issued photo identification.
    d. The following credentials are examples of acceptable proof of identity: Unexpired official identification issued by a Federal, State, or local government or by a territory or possession of the United States, such as a passport, U.S. driver's license, U.S. military ID card or Merchant Mariner's Document / Merchant Mariner Credential.

Privacy Act Statement

As required by Title 5 United States Code (U.S.C.) 552a (e)(3), the following information is provided when supplying personal information to the United States Coast Guard.

1. Authority for solicitation of the information: 46 U.S.C. 2104(a), 7101[c]-(e), 7306(a)(4), 7313[c](3), 7317(a), 8703(b), 9102(a)(5).
2. Principal purposes for which information is used:
   a. To determine if an applicant is physically capable of performing their duties.
   b. To ensure that a duly licensed or certified Physician (MD or DO) / Physician Assistant / Nurse Practitioner conducts the applicant's physical examination/certification and to verify the information as needed.
3. The routine uses which may be made of this information:
   a. This form becomes part of the applicant's file as documentary evidence that regulatory physical requirements have been satisfied and that the applicant is physically competent to hold a credential.
   b. The information becomes part of the total credential file and is subject to review by Federal agency casualty investigators.
   c. This information may be used by the United States Coast Guard and an Administrative Law Judge in determining causation of marine casualties and appropriate suspension and revocation action.
4. Disclosure of this information is voluntary, but failure to provide this information will result in non-issuance of a credential.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The United States Coast Guard estimates that the average burden for completing this form is 20 minutes. You may submit any comment concerning the accuracy of this burden estimate or any suggestions for reducing the burden to the National Maritime Center, 100 Forbes Drive, Martinsburg, WV 25404.

Applicant Name:
(First Name, MI, Last Name) _____

Date of Birth:
(mm/dd/yyyy) _____